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## ***Phone Numbers for Vermont Medicaid PBM Program***

### **MedMetrics Health Partners (MHP)**

#### **Clinical Call Center:**

#### **PA Requests**

Tel: 1-800-918-7549; Fax: 1-866-767-2649

Note: Fax requests are responded to within 24 hrs.

For urgent requests, please call MHP directly.

### **MHP Program Rep-Vermont:**

*Assistance with any issues related to the PBM program.*

Nancy Miner, CPhT, (o) 802-879-5638

(f): 802-879-5919

E-mail: nancy\_miner@medmetricsph.com

### **MHP Clinical Staff:**

Diane Neal, RPh (o): 802-879-5605

(f): 802-879-5919

E-mail: diane\_neal@medmetricsph.com

### **OVHA Medical Staff:**

#### *Medical Director*

Scott Strenio, M.D., (o) 802-879-5906;

(f) 802-879-5963

### **OVHA Clinical Staff:**

*General Clinical Assistance*

Pat Densmore, R.N., Clinical Operations Director

(o) 802-879-5903; (f) 802-879-5963

E-mail: Patricia.Densmore@ahs.state.vt.us

### **OVHA Pharmacy Unit Staff:**

Stacey Baker, (o) 802-879-5912;

(f) 802-879-5919

E-mail: Stacey.Baker@ahs.state.vt.us

## Acne Drugs: Oral

Length of Authorization: 1 year

### NO PA REQUIRED

DOXYCYCLINE† 20 mg, 50 mg, 75 mg, 100 mg tab, cap

ERY-TAB® (erythromycin base, delayed release)

ERYTHROCIN† (erythromycin stearate)

ERYTHROMYCIN BASE†

ERYTHROMYCIN ESTOLATE†

ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®,  
Eryped®)

ERYTHROMYCIN STEARATE†

MINOCYCLINE† 50 mg, 75 mg, 100 mg

TETRACYCLINE† 250 mg, 500 mg cap

SUMYCIN† 250 mg, 500 mg cap

ISOTRETINOIN† 10 mg, 20 mg, 40 mg cap (SOTRET,  
CLARAVIS, AMNESTEEM)

### PA REQUIRED

All brands:

Adoxa®\* (doxycycline monohydrate) 50 mg, 100 mg tab

Doryx®\* (doxycycline hyclate) 75 mg, 100 mg cap

Monodox®\* (doxycycline monohydrate) 50 mg, 100 mg cap

Oracea® (doxycycline monohydrate) 40 mg cap

Periostat®\* (doxycycline hyclate) 20 mg, 100 mg tab

Vibramycin®\* (doxycycline hyclate) 50 mg, 100 mg cap

Vibramycin® (doxycycline hyclate) suspension

Vibratab®\* (doxycycline hyclate) 100 mg tab

All other brands

E.E.S.®\* (erythromycin ethylsuccinate)

Eryc®\* (erythromycin base, delayed release)

Eryped® (erythromycin ethylsuccinate)

PCE Dispertab® (erythromycin base)

All other brands

Minocin®\* (minocycline) 50 mg, 75 mg, 100 mg cap

Dynacin®\* (minocycline) 50 mg, 75 mg, 100 mg cap/tab

Solodyn® (minocycline) 45 mg, 90 mg, 135 mg tabs

All other brands

Sumycin® (tetracycline) 250 mg, 500 mg tab

Sumycin® (tetracycline) 125 mg/5ml syrup

All other brands

Accutane®\* (isotretinoin) 10 mg, 20 mg, 40 mg caps

All other brands

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## **Acne Drugs: Topical Anti-Infectives**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

#### **BENZOYL PEROXIDE PRODUCTS**

BENZOYL PEROXIDE 2.5%, 5%, 10% G, L, W; 10% C; 3%, 5%, 6%, 8%, 9%, 10% L; 3%, 6%, 9% P †

#### **CLINDAMYCIN PRODUCTS**

CLINDAMYCIN 1% S, G, L, P †

#### **ERYTHROMYCIN PRODUCTS**

ERYTHROMYCIN 2% S, G, P †

#### **SODIUM SULFACETAMIDE PRODUCTS**

SODIUM SULFACETAMIDE 10% L†

#### **COMBINATION PRODUCTS**

ERYTHROMYCIN / BENZOYL PEROXIDE†

SODIUM SULFACETAMIDE / SULFUR L†

#### **OTHER**

*C=cream, E=emulsion, F=foam, G=gel, L=lotion, O=ointment, P=pads, S=solution, W=wash, B=bar*

### **PA REQUIRED**

Benzac AC® 2.5%, 5%, 10% G, W  
 Benzashave® 5%, 10% C  
 Brevoxyl® 4%, 8% W; 4% G; 4%, 8% L  
 Clinac BPO® 7% G  
 Desquam-E/X® 2.5%, 5%, 10% G; 5%, 10% W  
 Inova 4% P  
 Panoxyl/AQ 2.5%, 5%, 10% G; 5%, 10% B  
 Triaz® 3%, 6%, 9% G; 3%, 6%, 9% P  
 Zaclair® 4%, 8% L  
 All other brands

Cleocin-T®\* (clindamycin 2% G)  
 Evoclin® (clindamycin 2% F)  
 Clindagel® (clindamycin 1% G)  
 All other brands

Akne-Mycin® (erythromycin 2% O)  
 Erygel®\* (erythromycin 2% G)  
 All other brands

Klaron®\* (sodium sulfacetamide 10% L)  
 All other brands

Benzaclin®, DUAC® (clindamycin/benzoyl peroxide)  
 Benzamycin®\* (erythromycin/benzoyl peroxide)  
 Sulfoxy (erythromycin/benzoyl peroxide)  
 Z-Clinz® (clindamycin/benzoyl peroxide kit)  
 All other brands

Avar® (sodium sulfacetamide/sulfur G)  
 Sulfaet-R®\* (sodium sulfacetamide/sulfur L)  
 Plexion® (sulfacetamide/sulfur S)  
 All other brands

Azelex® (azelaic acid 20% C)  
 All other brands any topical acne anti-infective medication

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## Acne Drugs: Topical - Retinoids

Length of Authorization: 1 year

### NO PA REQUIRED

TRETINOIN† (specific criteria required for ages <10 or >34) 0.025%, 0.05%, 0.1% C; 0.01%, 0.025% G

TAZORAC® (tazarotene) 0.05%, 0.1% C, G

### PA REQUIRED

All brand tretinoin products (Avita®\*, Retin-A®\*, Retin-A Micro® 0.1%, 0.04%, Tretin-X® etc.)

Differin® (adapalene) 0.1% C, G

Avage® (tazarotene) ♣

Renova® (tretinoin) ♣

Solage® (tretinoin/mequinol) ♣

Tri-Luma® (tretinoin/hydroquinone/fluocinolone) ♣

♣ Not indicated for acne. Coverage of topical retinoid products will not be approved for cosmetic use (wrinkles, age spots, etc.).

C=cream, G=gel

## Acne Drugs: Topical - Rosacea

Length of Authorization: 1 year

### NO PA REQUIRED

METRONIDAZOLE† 0.75% C, G, L

### PA REQUIRED

All brand metronidazole products (MetroCream®\* 0.75% C, MetroGel®\* 0.75% G, MetroGel® 1% G, MetroLotion®\* 0.75% L, Noritate® 1% C, Rozex® 0.75% G etc.)

Finacea® (azelaic acid) 15% G

C=cream, G=gel, L=lotion

## Alzheimer's Medications: Cholinesterase/Glutamate Inhibitors

Length of Authorization: 1 year

### NO PA REQUIRED

ARICEPT® (donepezil)  
NAMENDA® (memantine)

### PA REQUIRED

Cognex® (tacrine) §  
Exelon® (rivastigmine) §  
Razadyne/Razadyne® CR (galantamine) §

## Analgesics: Actiq® Transmucosal

Length of Authorization: 3 months

### NO PA REQUIRED

### PA REQUIRED

Fentanyl lozenge on a stick: 200 mcg, 400 mcg, 600 mcg, 800 mcg, 1200 mcg, 1600 mcg

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## Analgesics: COX-2 Inhibitors

Length of Authorization: 1 year

### NO PA REQUIRED

CELEBREX® (celecoxib) (age > 60 yrs)

### PA REQUIRED

Celebrex® (age ≤ 60 yrs)

## Analgesics: Narcotics-Short Acting

Length of Authorization: 3 months, subsequent approval up to 6 months

Quantity limits apply

### NO PA REQUIRED

ACETAMINOPHEN W/CODEINE† (compare to Tylenol® w/codeine)  
ACETAMINOPHEN W/HYDROCODONE† (compare to Vicodin®, Loracet®, Maxidone®, Norco®, Zydome®)  
ACETAMINOPHEN W/OXYCODONE† (compare to Percocet®)  
ACETAMINOPHEN W/PROPOXYPHENE† (compare to Darvocet®)  
ASPIRIN W/CODEINE†  
ASPIRIN W/OXYCODONE† (compare to Percodan®)  
BUTALBITAL COMP. W/CODEINE† (compare to Fiorinal® w/codeine)  
CODEINE SULFATE†  
DIHYDROCODEINE COMPOUND† (compare to Synalgos-DC®)  
HYDROCODONE† (plain, w/acetaminophen, or w/ibuprofen)  
HYDROMORPHONE† (compare to Dilaudid®)  
MEPERIDINE† (compare to Demerol®) (30 tabs or 5 day supply)  
MORPHINE SULFATE†  
MORPHINE SULFATE† (compare to Roxanol®)  
OXYCODONE† (plain, w/acetaminophen or w/ibuprofen)  
PENTAZOCINE† (compare to Talwin®)  
PROPOXYPHENE† (compare to Darvon®)  
PROPOXYPHENE COMPOUND.† (compare to Darvon Compound®)  
PROPOXYPHENE N W/ ACETAMINOPHEN†  
ROXICET® (oxycodone w/ acetaminophen)  
ROXICODONE INTENSOL® (oxycodone w/ acetaminophen)  
ROXICODONE® (oxycodone HCL)  
TRAMADOL† (compare to Ultram®)

### PA REQUIRED

Acetaminophen w/ codeine: *all branded products*  
Acetaminophen w/ hydrocodone: *all branded products*  
Acetaminophen w/ oxycodone: *all branded products*  
Anexia®\*  
Bancap HC®  
Butorphanol NS (*authorization limited to 2 units/month*)  
Capital® w/Codeine\*  
Combunox®  
Darvocet-N®\*  
Darvon Compound®\*  
Darvon®\*  
Darvon-N®\*  
Demerol\*  
Dilaudid®\*  
Endocet®  
Endodan®  
Fioricet w/codeine®\*  
Lorcet®\* (also HD, PLUS)  
Lortab®\*  
Magnacet®  
Maxidone®  
Meperidine (*Qty > 30 tabs or 5 day supply*)  
Nalbuphine  
Norco®\*  
Nubain®\*  
Numorphan®  
Opana®  
Oxyfast®\*  
OxyIR®\*  
Panlor DC®\*  
Pentazocine and Naloxone  
Percocet®\*  
Percodan®\*  
Propoxyphene: *all branded products\**  
Roxanol®\*  
Stadol® (*authorization limited to 2 units/month*)  
Synalgos DC®\*  
Talacen®\*  
*continued on next page*

### PDL Key:

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*continued from previous page*  
Talwin®\* and brand combinations  
Talwin NX®\*  
Tylenol® #3\*  
Tylenol® #4\*  
Tylox®\*  
Ultracet®  
Ultram®\*  
Ultram ER®  
Vicodin®\*  
Vicoprofen®\*  
Wygesic®\*  
Xodol®  
Zydone®\*

## Analgesics: Narcotics-Long Acting

*Length of Authorization: initial approval 3 months, subsequent approval up to 6 months  
Quantity limits apply*

*Therapy Specific PA fax form for Long Acting Narcotics available on OVHA web-site.*

### NO PA REQUIRED

FENTANYL PATCH† (compare to Duragesic) 25 mcg/hr, 50 mcg/hr,  
(QL=15 patches/30 days)

FENTANYL PATCH† (compare to Duragesic) 75 mcg/hr, 100 mcg/hr,  
(QL=30 patches/30 days)

METHADONE†

MORPHINE SULFATE ER† (compare to MS Contin®)  
(QL=90 tablets/strength/30 days)

### PA REQUIRED

Avinza® (morphine sulfate XR) (QL= 30 capsules/strength/30 days)  
Dolophine®\*  
Duragesic-12® 12.5 mcg/hr (QL=15 patches/30 days)  
Duragesic®\* 25 mcg/hr, 50 mcg/hr, (QL=15 patches/30 days)  
Duragesic®\* 75 mcg/hr, 100 mcg/hr (QL= 30 patches/30 days)  
Fentanyl Patch† (compare to Duragesic) 12.5 mcg/hr (QL=15 patches/30 days)  
Kadian® (morphine sulfate XR) (QL= 60 capsules/strength/30 days)  
MS Contin®\* (QL=90 tablets/strength/30 days)  
Opana ER® (QL=60 tablets/strength/30 days)  
Oramorph SR®\* (QL=90 tablets/strength/30 days)  
Oxycodone ER† (QL=90 tablets/strength/30 days)  
OxyContin® (QL= 90 tablets/strength/30 days)

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## **Analgesics: NSAIDs**

*Length of Authorization: 1 year*

**Quantity limits apply**

### **NO PA REQUIRED**

DICLOFENAC POTASSIUM† (compare to Cataflam®)  
 DICLOFENAC SODIUM† (compare to Voltaren®)  
 DIFLUNISAL† (compare to Dolobid®)  
 ETODOLAC† (compare to Lodine®)  
 FENOPROFEN† (compare to Nalfon®)  
 FLURBIPROFEN† (compare to Ansaid®)  
 IBUPROFEN† (compare to Motrin®)  
 INDOMETHACIN† (compare to Indocin®)  
 KETOPROFEN† (compare to Orudis®)  
 KETOPROFEN ER† (compare to Oruvail®)  
 MECLOFENAMATE SODIUM† (compare to Meclomen®)  
 NABUMETONE† (compare to Relafen®)  
 NAPROXEN† (compare to Naprosyn®)  
 NAPROXEN SODIUM† (compare to Anaprox®, Naprelan®)  
 OXaprozin† (compare to Daypro®)  
 PIROXICAM† (compare to Feldene®)  
 SULINDAC† (compare to Clinoril®)  
 TOLMETIN SODIUM† (compare to Tolectin®)

### **PA REQUIRED**

Anaprox®\*  
 Anaprox DS®\*  
 Ansaid®\*  
 Arthrotec®  
 Cataflam®\*  
 Clinoril®\*  
 Daypro®\*  
 Dolobid®\*  
 EC-Naprosyn®\*  
 Feldene®\*  
 Indocin®\*  
 Indocin SR®  
 Ketorolac† *QL = 20 doses post PA approval*  
 Lodine®\*  
 Lodine XL®\*  
 meloxicam  
 Mobic®  
 Motrin®\*  
 Nalfon®\*

Naprelan®\*  
 Naprosyn®\*  
 Orudis® \*  
 Oruvail®\*  
 Ponstel®  
 Relafen®\*  
 Tolectin®\*  
 Toradol® *QL = 20 doses post PA approval*  
 Voltaren®\*  
 Voltaren XR® \*

## **Analgesics: Stadol (butorphanol) Nasal Spray**

*Length of Authorization: 1 year*

**Quantity limits apply**

### **NO PA REQUIRED**

### **PA REQUIRED**

Stadol® (butorphanol) Nasal Solution: all forms brand & generic  
*(QL = 2 units/month)*

## **Anemia: Hematopoietic/Erythropoietic Agents**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

ARANESP® (darbepoetin alfa)  
 PROCRIT® (epoetin alpha)

### **PA REQUIRED**

Epogen® (epoetin alpha)

## **Anti-anxiety: Anxiolytics**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

ALPRAZOLAM† (compare to Xanax®)  
 BUSPIRONE† (compare to BuSpar®)  
 CHLORDIAZEPoxide† (compare to Librium®)  
 CLONAZEPAM† (compare to Klonopin®)  
 CLORAZEPATE† (compare to Tranxene®)  
 DIAZEPAM† (compare to Valium®)  
 LORAZEPAM† (compare to Ativan®)  
 MEPROBAMATE† (compare to Equanil®, Miltown®)  
 OXAZEPAM† (compare to Serax®)

### **PA REQUIRED**

Ativan®\*  
 BuSpan®\*  
 Equanil®\*  
 Klonopin®\*  
 Klonopin Wafers®  
 Librium®\*  
 Miltown®\*

Niravam®  
 Serax®\*  
 Tranxene®\* (all brand forms)  
 Valium®\*  
 Xanax®\*  
 Xanax XR®

### **PDL Key:**

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§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Anticoagulants

*Length of Authorization: 6 months*

**Quantity limits apply**

### NO PA REQUIRED

WARFARIN (compare to Coumadin®)

HEPARIN

LOVENOX® (enoxaparin) (*QL = 2 syringes/day calculated in ml volume*)

ARIIXTRA® (fondiparinux)

### PA REQUIRED

Coumadin® (warfarin)

n/a

Fragmin® (dalteparin)

Innohep® (tinzaparin)

## Anticonvulsants

*Length of Authorization: lifetime*

### NO PA REQUIRED

CARBAMAZEPINE† (compare to Tegretol®)

CARBATROL® (carbamazepine)

CELONTIN® (methsuxamide)

DEPAKOTE® (divalproex sodium)

DEPAKOTE ER® (divalproex sodium)

DIASSTAT® (diazepam rectal gel)

DILANTIN® (phenytoin)

EPITOL† (carbamazepine)

ETHOSUXAMIDE† (compare to Zarontin®)

FELBATOL® (felbamate)

GABAPENTIN† (compare to Neurontin®)

GABITRIL® (tiagabine)

KEPPRA® (levetiracetam)

LAMICTAL® tabs (lamotrigine tabs)

LAMICTAL® chew tabs (lamotrigine chew tabs)

LYRICA® (pregabalin)

NEURONTIN® oral solution (gabapentin)

PEGANONE® (ethotoin)

PHENYTEK® (phenytoin)

PHENYTOIN† (compare to Dilantin®)

PRIMIDONE† (compare to Mysoline®)

TEGRETOL XR® (carbamazepine)

TOPAMAX® (topiramate)

TRILEPTAL® (oxcarbazepine)

VALPROIC ACID† (compare to Depakene®)

ZONISIMIDE† (compare to Zonegran®)

### PA REQUIRED

Depakene®\* (valproic acid)

Gabarone® ( gabapentin)

Lamotrigine† chew tabs (compare to Lamictal® chew tabs)

Mysoline®\* (primidone)

Neurontin®\* ( gabapentin)

Tegretol®\* ( carbamazepine)

Zarontin®\* ( ethosuxamide)

Zonegran®\* ( zonisamide)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

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**Anti-depressants: Novel**  
**Length of Authorization: 1 year**  
**Quantity limits apply**  
**Suggested daily dosage limits**

**NO PA REQUIRED**

BUDEPRION®/BUPROPION SR† (compare to Wellbutrin SR®)  
*suggested max dose = 400 mg/day*  
 BUPROPION† (compare to Wellbutrin®)  
 MAPROTILINE† (compare to Ludomil®)  
 MIRTAZAPINE† (compare to Remeron®) *suggested max dose = 90 mg/day*  
 MIRTAZAPINE RDT† (compare to Remeron Sol-Tab®) *suggested max dose = 90 mg/day*  
 NEFAZADONE† (compare to Serzone®) *suggested max dose = 750 mg/day*  
 TRAZODONE HCL† (compare to Desyrel®) *suggested max dose = 750 mg/day*  
 WELLBUTRIN XL®

**PA REQUIRED**

Bupropion XL† (compare to Wellbutrin XL®)  
 Cymbalta®  
 Desyrel®\* *suggested max dose = 750 mg/day*  
 Effexor®  
 Effexor XR® *suggested max dose = 450 mg/day,  
 QL = 1 cap/day (37.5 mg & 75 mg caps)*  
 Remeron®\* *suggested max dose = 90 mg/day*  
 Remeron Sol Tab®\* *suggested max dose = 90 mg/day*  
 venlafaxine IR  
 Wellbutrin®\*  
 Wellbutrin SR®\* *suggested max dose = 400 mg/day*

**Anti-depressants: SSRIs**  
**Length of Authorization: 1 year**  
**Quantity limits apply**  
**Suggested daily dosage limits**

**NO PA REQUIRED**

CITALOPRAM† (compare to Celexa®) *suggested max dose = 75 mg/day*  
 FLUOXETINE† (compare to Prozac®) *suggested max dose = 100 mg/day*  
 FLUVOXAMINE† (compare to Luvox®) *suggested max dose = 300 mg/day*  
 PAROXETINE HCL† (compare to Paxil®) *suggested max dose = 75 mg/day*  
 SERTRALINE† (compare to Zoloft®) *suggested max dose = 250 mg/day,  
 QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

**PA REQUIRED**

Celexa®\* *suggested max dose = 75 mg/day*  
 Lexapro® *suggested max dose = 25 mg/day,  
 QL = 1.5 tabs/day (5 mg & 10 mg tabs)*  
 Luvox®\* *suggested max dose = 300 mg/day*  
 Paxil®\* *suggested max dose = 75 mg/day*  
 Paxil CR® *suggested max dose = 75 mg/day*  
 Pexeva® *suggested max dose = 75 mg/day*  
 Prozac®\* *suggested max dose = 100 mg/day*  
 Prozac Weekly® *suggested max weekly dose = 540 mg*  
 Sarafem® *suggested max dose = 100 mg/day*  
 Zoloft® *suggested max dose = 250 mg/day , QL = 1.5 tabs/day (25 mg & 50 mg tabs)*

**Anti-depressants: Tricyclics**  
**Length of Authorization: 1 year**  
**Suggested daily dosage limits**

**NO PA REQUIRED**

AMITRIPTYLINE† (compare to Elavil®) *suggested max dose = 375 mg/day*  
 AMITRIPTYLINE/CHLORDIAZ.† (compare to Limbitrol®)  
 AMITRIPTYLINE/PERPHEN†.(compare to Etrafon®, Triavil®)  
 AMOXAPINE† (compare to Asendin®)  
 CLOMIPRAMINE† (compare to Anafranil®)  
 DESIPRAMINE† (compare to Norpramin®)  
 DOXEPIN† (compare to Sinequan®)  
 IMIPRAMINE† (compare to Tofranil®) *suggested max dose = 250 mg/day*  
 NORTRIPTYLINE† (compare to Aventyl®, Pamelor®)  
 TOFRANIL PM® (imipramine pamoate)  
 TRIMIPRAMINE† (compare to Surmontil®)  
 VIVACTIL® (protriptyline)

**PA REQUIRED**

Anafranil®\*  
 Aventyl®\*  
 Elavil®\*  
 Limbitrol®\*  
 Limbitrol DS®  
 Norpramin®\*  
 Pamelor®\*  
 Sinequan®\*  
 Surmontil®\*  
 Tofranil®\*

**PDL Key:**

† Generic product

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## **Anti-depressants: MAO Inhibitors**

*Length of Authorization: 1 year*

**Quantity limits apply**

**Suggested daily dosage limits**

### **NO PA REQUIRED**

NARDIL® (phenylzine) suggested max dose = 110 mg/day  
TRANYLCYPROMINE† (compare to Parnate®) suggested max dose = 120 mg/day

### **PA REQUIRED**

EMSAM® (selegiline) (QL = 1 patch/day)  
Marplan® (isocarboxazid)  
Parnate®\*

## **Anti-diabetics: Alpha-Glucosidase Inhibitors**

*Length of Authorization: n/a*

### **NO PA REQUIRED**

GLYSET® (miglitol)  
PRECOSE® (acarbose)

### **PA REQUIRED**

## **Anti-diabetic: Biguanides & Combinations**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

GLIPIZIDE/METFORMIN† (compare to Metaglip®)  
GLYBURIDE/METFORMIN† (compare to Glucovance®)  
METFORMIN† (compare to Glucophage®)  
METFORMIN XR† (compare to Glucophage XR®)

### **PA REQUIRED**

Fortamet®  
Glucophage®\*  
Glucophage XR®\*  
Glucovance®\*  
Glumetza®  
Metaglip®\*

## **Anti-diabetics: Peptide Hormones**

*Length of Authorization: 1 year*

**Quantity limits apply**

### **PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Byetta® (exenatide) § (*Quantity Limit = 1 pen/30 days*)

### **PA REQUIRED**

Symlin® (pramlintide) *No Quantity Limit*

### **PDL Key:**

† Generic product

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## **Anti-diabetics: Insulins**

*Length of Authorization: lifetime*

### **NO PA REQUIRED**

#### **RAPID-ACTING INJECTABLE**

NOVOLOG® (Aspart)

#### **SHORT-ACTING INJECTABLE**

NOVOLIN R® (Regular)  
RELION R® (Regular)

#### **INTERMEDIATE-ACTING INJECTABLE**

NOVOLIN N® (NPH)  
RELION N® (NPH)

#### **LONG-ACTING ANALOGS INJECTABLE**

LANTUS® (insulin glargine)  
LEVEMIR® VIAL (insulin detemir)

#### **MIXED INSULINS INJECTABLE**

HUMULIN 50/50® (NPH/Regular)  
NOVOLIN 70/30® (NPH/Regular)  
RELION 70/30® (NPH/Regular)

NOVOLOG MIX 70/30® (Protamine/Aspart)

HUMALOG MIX 50/50® (Protamine/Lispro)  
HUMALOG MIX 75/25® (Protamine/Lispro)

### **PA REQUIRED**

Apidra® (insulin glulisine)  
Humalog® (insulin lispro)

Humulin R® (Regular)

Humulin N® (NPH)

Levemir® pen (insulin detemir)

Humulin 70/30® (NPH/Regular)

#### **INHALED**

Exubera® (insulin human [rDNA] Inhalation Powder )

## **Anti-diabetic: Oral Meglitinides**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

STARLIX® (nateglinide)

### **PA REQUIRED**

Prandin® (replaglinide)

## **Anti-diabetic: Sulfonylureas 2nd Generation**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

GLIMEPIRIDE† (compare to Amaryl®)  
GLIPIZIDE† (compare to Glucotrol®)  
GLIPIZIDE ER† (compare to Glucotrol XL®)  
GLYBURIDE† (compare to Diabeta®, Micronase®)  
GLYBURIDE MICRONIZED† (compare to Glynase® PresTab®)

### **PA REQUIRED**

Amaryl®\*  
Diabeta®\*  
Glucotrol®\*  
Glucotrol XL®\*  
Glynase® PresTab®\*  
Micronase®\*

#### **PDL Key:**

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## Anti-diabetic: Thiazolidinediones & Combinations

Length of Authorization: n/a

### NO PA REQUIRED

ACTOPLUS MET® (metformin/pioglitazone)  
ACTOS® (pioglitazone)  
AVANDAMET® (metformin/rosiglitazone maleate)  
AVANDARYL® (glimepiride/rosiglitazone maleate)  
AVANDIA® (rosiglitazone)

### PA REQUIRED

## Anti-emetics: NK1/5HT3 Antagonists

Length of Authorization: 6 months of chemotherapy or radiotherapy;

1 time for post-op nausea/vomiting: see clinical criteria.

Monthly quantity limits apply, PA required to exceed.

### NO PA REQUIRED

EMEND® (aprepitant) 40 mg (1 cap)  
\*EMEND® (aprepitant) 80 mg (2 caps)  
\*EMEND® (aprepitant) 125 mg (1 cap)  
\*EMEND® (aprepitant) Tri-fold Pack (1 pack)  
ONDANSETRON† Injection (vial and premix)  
ZOFRAN® (ondansetron) 24 mg (1 tab), 8 mg (6 tabs), 4 mg (12 tabs)  
ZOFRAN (ondansetron) ODT® 4 mg (12 tabs), 8 mg (6 tabs)  
ZOFRAN® (ondansetron) Solution 4 mg/5 ml  
\* Limited to oncologist prescribing only

### PA REQUIRED

Aloxi® (palonosetron, injectable) (2 vials)  
Anzemet® (dolansetron) 50 mg (4 tabs)  
Anzemet® (dolansetron) 100 mg (2 tabs)  
Kytril® (gransetron) 1 mg (6 tabs)  
Kytril® (gransetron) Injectable  
Ondansetron† (generic) – all oral forms – quantity limits apply  
Zofran®\* Injection

## Antihyperkinesis: ADHD, ADD, Narcolepsy

Length of Authorization: up to 1 year

CNS Stimulants (all forms short- & long-acting): PA'd for beneficiaries < 3 yrs

Quantity limits apply

### NO PA REQUIRED

#### SHORT/INTERMEDIATE ACTING METHYLPHENIDATE PREPS

METADATE ER® (compare to Ritalin® SR)  
METHYLIN® (compare to Ritalin®)  
METHYLIN® ER (compare to Ritalin® SR)  
METHYLPHENIDATE† (compare to Ritalin®)  
METHYLPHENIDATE SR† (compare to Ritalin® SR)

### PA REQUIRED

Focalin® (dexmethylphenidate)  
Ritalin®\*  
Ritalin SR®\*

#### LONG-ACTING METHYLPHENIDATE PREPS

FOCALIN® XR (dexmethylphenidate IR/ER, 50:50%)  
CONCERTA® (methylphenidate IR/ER 22:78%)

Metadate CD® (methylphenidate, IR/ER, 30:70%)  
Ritalin LA® (methylphenidate, IR/ER, 50:50%)  
Daytrana® (methylphenidate patch) (QL = 1 patch/day)

#### SHORT/INTERMEDIATE AMPHETAMINE PREPS

AMPHETAMINE salt combination† (compare to Adderall®)  
DEXTROAMPHETAMINE† (compare to Dexedrine®)  
DEXTROAMPHETAMINE SA† (compare to Dexedrine SA®)  
DEXTROSTAT® (compare to Dexedrine®)

Adderall®\*  
Desoxyn® (methamphetamine)  
Dexedrine®\*  
Dexedrine SA®\*

#### LONG-ACTING AMPHETAMINE PREPS

ADDERALL XR® (dextroamphetamine IR/ER, 50:50%)

Provigil® (modafinil) (not approvable for ADHD in children age ≤ 12)  
Strattera® (atomoxetine) max dose = 100 mg/day

#### NON-STIMULANT PREPS

#### PDL Key:

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## Anti-hypertensives: ACE Inhibitors

*Length of Authorization: 1 year*

### NO PA REQUIRED

BENAZEPRIL† (compare to Lotensin®)  
 CAPTOPRIL† (compare to Capoten®)  
 ENALAPRIL† (compare to Vasotec®)  
 FOSINOPRIL† (compare to Monopril®)  
 LISINOPRIL† (compare to Zestril®, Prinivil®)  
 QUINAPRIL† (compare to Accupril®)

### PA REQUIRED

Accupril®\*  
 Aceon® (perindopril)  
 Altace® (ramipril)  
 Capoten®\*  
 Lotensin®\*  
 Mavik® (trandolapril)  
 Monopril®\*

Prinivil®\*  
 trandolapril† (compare to Mavik®)  
 Univasc® (moexipril)  
 Vasotec®\*  
 Zestril®\*

## Anti-hypertensives: ACE Inhibitor with Hydrochlorothiazide

*Length of Authorization: 1 year*

### NO PA REQUIRED

BENAZEPRIL/HYDROCHLOROTHIAZIDE† (compare to Lotensin HCT®)  
 CAPTOPRIL/HYDROCHLOROTHIAZIDE† (compare to Capozide®)  
 ENALAPRIL/HYDROCHLOROTHIAZIDE† (compare to Vaseretic®)  
 FOSINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Monopril HCT®)  
 LISINOPRIL/HYDROCHLOROTHIAZIDE† (compare to Zestoretic®, Prinzide®)  
 QUINAPRIL/HYDROCHLOROTHIAZIDE† (compare to Accuretic®)

### PA REQUIRED

Accuretic®\*  
 Capozide®\*  
 Lotensin HCT®\*  
 moexipril/hydrochlorothiazide†  
 Monopril HCT®\*  
 Prinzide®\*  
 Uniretic® (moexipril/hydrochlorothiazide)  
 Vaseretic®\*  
 Zestoretic®\*

## Anti-hypertensives: ACE Inhibitor w/Calcium Channel Blocker

*Length of Authorization: 1 year*

### NO PA REQUIRED

LOTREL® (amlodipine/benazepril)  
 TARKA® (trandolapril/verapamil)

### PA REQUIRED

Lexxel® (enalapril/felodipine)

## Anti-hypertensives: Angiotensin Receptor Blockers (ARBs)

*Length of Authorization: lifetime*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

BENICAR® (olmesartan) §  
 COZAAR® (losartan) §  
 DIOVAN® (valsartan) §  
 MICARDIS® (telmisartan) §

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand® (candesartan) §  
 Avapro® (irbesartan) §  
 Teveten® (eprosartan) §

## Anti-hypertensives: Angiotensin Receptor Blockers/Hydrochlorothiazide Combinations

*Length of Authorization: lifetime*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

BENICAR HCT® (olmesartan/hydrochlorothiazide) §  
 DIOVAN HCT® (valsartan/hydrochlorothiazide) §  
 HYZAAR® (losartan/hydrochlorothiazide) §  
 MICARDIS HCT® (telmisartan/hydrochlorothiazide) §

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Atacand HCT® (candesartan/hydrochlorothiazide) §  
 Avalide® (irbesartan/hydrochlorothiazide) §  
 Teveten HCT® (eprosartan/hydrochlorothiazide) §

### PDL Key:

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## Anti-hypertensives: Beta Blockers

*Length of Authorization: 5 years*

### NO PA REQUIRED

ACEBUTOLOL† (compare to Sectral®)  
 ATENOLOL† (compare to Tenormin®)  
 ATENOLOL/CHLORTHALIDONE † (compare to Tenoretic®)  
 BETAXOLOL† (compare to Kerlone®)  
 BISOPROLOL FUMARATE† (compare to Zebeta®)  
 BISOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Ziac®)  
 COREG® (carvedilol)  
 LABETALOL† (compare to Normodyne®, Trandate®)  
 METOPROLOL† (compare to Lopressor®)  
 METOPROLOL/HYDROCHLOROTHIAZIDE† (compare to Lopressor HCT®)  
 NADOLOL† (compare to Corgard®)  
 PINDOLOL† (compare to Visken®)  
 PROPRANOLOL† (compare to Inderal®)  
 PROPRANOLOL/HYDROCHLOROTHIAZIDE† (compare to Inderide®)  
 SOTALOL† (compare to Betapace®, Betapace AF®)  
 TIMOLOL† (compare to Blocadren®)

### PA REQUIRED

Betapace®\*  
 Betapace AF®\*  
 Blocadren®\*  
 Cartrol®  
 Corgard®  
 Corzide®  
 Inderal®\* (all products)  
 Inderal LA®  
 Inderide®\*  
 Innopran XL®  
 Kerlone®\*  
 Levatol® (penbutolol )  
 Lopressor®\* (all products)  
 Lopressor HCT®\*  
 propranolol ER† (compare to  
 Inderal LA®)

## Anti-hypertensives: Calcium Channel Blockers

*Length of Authorization: 5 years*

### NO PA REQUIRED

CARTIA XT® (diltiazem HCL)  
 DILTIA XT® (diltiazem HCL)  
 DILTIAZEM† (compare to Cardizem®)  
 DILTIAZEM ER† (compare to Cardizem® SR)  
 DILTIAZEM CD† (compare to Cardizem® CD)  
 DILTIAZEM XR† (compare to Dilacor® XR)  
 FELODIPINE† (compare to Plendil®)  
 NICARDIPINE† (compare to Cardene®)  
 NIFEDIAC® CC (compare to Adalat CC®)  
 NIFEDICAL XL† (compare to Procardia® XL)  
 NIFEDIPINE IR† (compare to Procardia®)  
 NIFEDIPINE ER† (compare to Procardia® XL)  
 NIMOTOP® (nimodipine)  
 NORVASC® (amlodipine)  
 SULAR® (nisoldipine)  
 TAZTIA XT® (compare to Tiazac®)  
 VERAPAMIL† (compare to Calan®, Isoptin®)  
 VERAPAMIL SR† (compare to Calan SR®, Isoptin SR®)  
 VERAPAMIL ER† (compare to Covera-HS®, Verelan® )

### PA REQUIRED

Adalat® CC\*  
 amlodipine† (compare to Norvasc®)  
 Caduet® (amlodipine/atorvastatin)  
 Calan®\*  
 Calan® SR\*  
 Cardene®\*  
 Cardene® SR\*  
 Cardizem®, all: CD, LA, SR  
 Covera-HS®\*  
 Dilacor® XR\*  
 Dynacirc®  
 Dynacirc CR®  
 Isoptin®\*  
 Isoptin® SR\*  
 Plendil®\*  
 Procardia®  
 Procardia® XL\*  
 Tiazac®\*  
 Vascor®  
 Verelan®\*  
 Verelan PM®

## Anti-infectives: Cephalosporins – 1<sup>st</sup> Generation

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

CEFADROXIL† (compare to Duricef®, Ultracef®)  
 CEPHALEXIN† (compare to Keflex®)

IV drugs are not managed at this time

### PA REQUIRED

cephradine† (compare to Velosef®)  
 Duricef®\*  
 Keflex®\*  
 Velosef®

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Anti-infectives: Cephalosporins – 2<sup>nd</sup> Generation

*Length of Authorization: for date of service, only: no refills*

### NO PA REQUIRED

CEFACLOR† (compare to Ceclor)  
 CEFACLOR ER† (compare to Ceclor CD®)  
 CEFACLOR SUSPENSION† (age ≤ 10 yrs)  
 CEFPROZIL SUSPENSION† (age ≤ 12 yrs)  
 CEFPROZIL† (compare to Cefzil®) tablets  
 CEFTIN® (cefuroxime) SUSPENSION (age ≤ 12 yrs)  
 CEFUROXIME† (compare to Ceftin®) tablets

IV drugs are not managed at this time

### PA REQUIRED

Ceclor®\*  
 Ceclor CD®\*  
 cefaclor suspension† (age > 10 yrs)  
 cefprozil suspension† (age > 12 years)  
 Ceftin®\* tablets (all ages)  
 Ceftin® suspension (age > 12 yrs)  
 Cefzil®  
 Lorabid® (loracarbef)

## Anti-infectives: Cephalosporins – 3<sup>rd</sup> Generation

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

CEDAX® (ceftibuten)  
 CEFPODOXIME PROXETIL TABS† (compare to Vantin®)  
 OMNICEF® (cefdinir)  
 SUPRAX® (cefixime)

IV drugs are not managed at this time

### PA REQUIRED

cefdinir †  
 cefpodoxime proxetil† (compare to Vantin®) suspension  
 Spectacef® (cefditoren)  
 Vantin®\* (cefpodoxime) tabs, suspension

## Anti-infectives: Ketolides

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

### PA REQUIRED

Ketek® (telithromycin)

## Anti-infectives: Macrolides

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

AZITHROMYCIN† tablets (< = 5 day supply) (compare to Zithromax®)  
 AZITHROMYCIN† liquid (< = 5 day supply) (compare to Zithromax®)  
 CLARITHROMYCIN† (compare to Biaxin/Biaxin XL)  
 ERY-TAB® (erythromycin base, delayed release)  
 ERYTHROCIN† (erythromycin stearate)  
 ERYTHROMYCIN BASE†  
 ERYTHROMYCIN ESTOLATE†  
 ERYTHROMYCIN ETHYLSUCCINATE† (compare to E.E.S.®, Eryped®)  
 ERYTHROMYCIN STEARATE†  
 ERYTHROMYCIN W/ SULFASOXAZOLE† (compare to Pedazole®)

IV drugs are not managed at this time

### PA REQUIRED

azithromycin† tablets and liquid (if > 5 day supply)  
 Biaxin®\*  
 Biaxin XL®  
 Dynabac® (dirithromycin)  
 E.E.S.®\*  
 Eryc®\* (erythromycin base, delayed release)  
 Eryped® (erythromycin ethylsuccinate)  
 Pedazole®\* (erythromycin-sulfisoxazole)  
 Zithromax® tablets and liquid  
 Zmax® (azithromycin extended release oral suspension)

## Anti-infectives: Oxazolidinones

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

### PA REQUIRED

Zyvox® (linezolid)

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## **Anti-infectives: Penicillins (Oral)**

**Length of Authorization: for date of service, no refills**

### **NO PA REQUIRED**

AMOXICILLIN† (compare to Amoxil®, Trimox®, DisperMox™)  
 AMOXICILLIN/CLAVULANATE† (compare to Augmentin®)  
 AMPICILLIN† (compare to Principen®)  
 DICLOXACILLIN†  
 PENICILLIN VK† (compare to Veetids®)

### **PA REQUIRED**

Augmentin®\*‡  
 Augmentin ES®\*  
 Augmentin XR®

\* PA will be granted for 125 mg/5 mL strength for patients < 12 weeks of age

## **Anti-infectives: Quinolones**

**Length of Authorization: for date of service, no refills**

**Monthly quantity limits apply**

### **NO PA REQUIRED**

CIPROFLOXACIN† (compare to Cipro®) 100 mg (6), 250 mg (28), 500 mg (28), 750 mg (28) tabs  
 CIPRO® OS (ciprofloxacin) 100 mg/ml  
 LEVAQUIN® (levofloxacin) 250 mg (10), 500 mg (14), 750 mg (14)  
 OFLOXACIN† (compare to Floxin®) 200 mg (14), 300 mg (14), 400 mg (28) tabs

IV drugs are not managed at this time

### **PA REQUIRED**

Avelox® (moxifloxacin HCL) 400 mg (10 tabs)  
 Avelox ABC PACK® (moxifloxacin HCL)  
 Cipro®\* 100 mg (6), 250 mg (28), 500 mg (28), 750 mg (28) tabs  
 Cipro XR® (7 days)  
 Ciprofloxacin ER† 500 mg, 1000 mg (7 days)  
 Factive® (gemifloxacin) 320 mg (14 tabs)  
 Floxin®\* 200mg (14), 300 mg (14), 400 mg (28) tabs  
 Noroxin® (norfloxacin) 400mg (20 tabs)  
 ProQuin XR® (ciprofloxacin) 500 mg (3 tabs)  
 Tequin® (gatifloxacin) 200 mg (3 tabs), 400 mg (10 tabs)

## **Anti-infectives: Onychomycosis Agents**

**Length of Authorization: 1 year, see clinical criteria.**

**Monthly quantity limits apply**

### **PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

LAMISIL® tablets (terbinafine HCL) QL = 30 tablets/month  
 PENLAC® Nail Lacquer (ciclopirox) QL = 6.6 ml/90 days

### **NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Sporanox® (itraconazole) QL = 28 capsules/month (brand & generic)

## **Anti-infectives: Anti-virals: Herpes**

**Length of Authorization: for duration of prescription, up to 6 months.**

### **NO PA REQUIRED**

ACYCLOVIR† (compare to Zovirax®)  
 VALTREX® (valacyclovir)

### **PA REQUIRED**

Famvir® (famciclovir) §  
 Zovirax®\* §

## **Anti-infectives: Genital Antivirals**

**Length of Authorization: 1 month**

### **NO PA REQUIRED**

ALDARA® (imiquimod)  
 CONDYLOX® GEL (podofilox gel)  
 PODOFILOX SOLUTION† (compare to Condylox®)

### **PA REQUIRED**

Condylor®\* solution (podofilox solution)

### **PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## **Anti-infectives: Influenza Medications**

*Length of Authorization: for duration of prescription, up to 3 months.*

**Quantity limits apply**

### **NO PA REQUIRED**

RELENZA® (zanamivir) *QL= 20 blisters / 30 days*  
TAMIFLU® (oseltamivir) *QL=10 capsules or 75 ml /30 days*

### **PA REQUIRED**

amantadine† PA for quantity  $\leq 10$  days supply (*Not CDC recommended for use in influenza*)  
Flumadine® (rimantidine) (*Not CDC recommended for use in influenza*)  
rimantadine† (*Not CDC recommended for use in influenza*)  
Symmetrel® (amantadine) (*Not CDC recommended for influenza*)

## **Anti-infectives: Influenza Vaccines**

*Length of Authorization: for date of service only*

### **NO PA REQUIRED**

FLUARIX® Injection  
FLUZONE® Injection  
FLUVIRIN® Injection

### **PA REQUIRED**

FluMist® Nasal

## **Anti-infectives: Miscellaneous**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

### **PA REQUIRED**

Qualaquin® (quinine sulfate)

## **Anti-infectives: Topical Antibiotics**

*Length of Authorization: n/a*

### **NO PA REQUIRED**

BACITRACIN†  
GENTAMICIN†  
BACITRACIN-POLYMICIN†  
NEOMYCIN-BACITRACIN-POLYMICIN†  
CORTISPORIN®  
BACTROBAN® (all forms)  
MUPIROCIN OINTMENT (compare to Bactroban®)

### **PA REQUIRED**

## **Anti-migraine: Triptans**

*Length of Authorization: 6 months*

**Monthly quantity limits apply, PA required to exceed.**

### **NO PA REQUIRED, Quantity Limits Apply**

AXERT® (almotriptan) 6.25 mg, 12.5 mg (*QL = 6 tabs*)  
IMITREX® (sumatriptan) Injection 6 mg (*QL = 4 inj.*)  
IMITREX® NS (sumatriptan) 20 mg (*QL = 6 units*)  
IMITREX® NS (sumatriptan) 5 mg (*QL = 12 units*)  
IMITREX® (sumatriptan) 25 mg (*QL = 18 tabs*)  
IMITREX® (sumatriptan) 50 mg, 100 mg (*QL = 9 tabs*)  
MAXALT-MLT® (rizatriptan) 5 mg, 10 mg (*QL = 12 tabs*)  
MAXALT® (rizatriptan) 5 mg, 10 mg (*QL = 12 tabs*)

### **PA REQUIRED, Quantity Limits Apply**

Amerge® (naratriptan) 1 mg, 2.5 mg (*QL = 9 tabs*)  
Frova® (frovatriptan) 2.5 mg (*QL = 9 tabs*)  
Relpax® (eletriptan) 20 mg, 40 mg (*QL = 12 tabs*)  
Zomig® (zolmitriptan) ZMT 2.5 mg (*QL = 12 tabs*), 5 mg (*QL = 6 tabs*)  
Zomig® 2.5 mg (*QL = 12 tabs*)  
Zomig® 5 mg (*QL = 6 tabs*)  
Zomig® Nasal Spray (*QL = 12 units*)

## **PDL Key:**

† Generic product

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## **Anti-narcolepsy/cataplexy: Xyrem®**

**Length of Authorization: 1 year**

*Therapy specific clinical criteria are available on the OVHA website.*

**NO PA REQUIRED**

**PA REQUIRED**

Xyrem® (sodium oxybate)

## **Anti-obesity**

**Length of Authorization: 6 months for initial approval,  
may renew for additional 6 months if patient has met target goals.**

*Therapy specific PA fax form available on OVHA website.*

**NO PA REQUIRED**

**PA REQUIRED**

Didrex® (benzphetamine)  
Diethylpropion (all forms brand & generic)  
Meridia® (sibutramine)  
Phentermine (all forms brand & generic)  
Phendimetrazine (all forms brand & generic)  
Xenical® (orlistat)

## **Anti-psychotic: Atypical & Combinations**

**Length of Authorization: duration of need or lifetime**

**Quantity limits apply**

**Suggested daily dosage limits**

**NO PA REQUIRED**

CLOZAPINE† (compare to Clozaril®) suggested max dose = 1125 mg/day  
GEODON® (ziprasidone) suggested max dose = 200 mg/day  
GEODON IM® (ziprasidone Injectable)  
RISPERDAL® (risperidone) suggested max dose = 10 mg/day  
SEROQUEL® (quetiapine) suggested max dose = 1000 mg/day

**PA REQUIRED**

Abilify® (aripiprazole) all forms, suggested max dose = 40 mg/day, QL = 1.5 tabs/day (5 mg, 10 mg & 15 mg tabs)  
Clozaril®\* suggested max dose = 1125 mg/day  
Fazaclor® (clozapine ODT) suggested max dose = 1125 mg/day  
Risperdal Consta® (risperidone microspheres)  
Risperdal Tab Rapidis® (risperidone rapid dissolve tab) suggested max dose = 10 mg/day  
Symbax® (olanzapine/fluoxetine)  
Zyprexa® (olanzapine) suggested max dose = 50 mg/day, QL = 1.5 tabs/day (2.5 mg, 5 mg, 7.5 mg, & 10 mg tabs)  
Zyprexa IM® (olanzapine injectable)  
Zyprexa Zydis® (olanzapine rapid dissolve tab) suggested max dose = 50 mg/day, QL = 1.5 tabs/day (5 mg & 10 mg tabs)

## **Anti-psychotic: Typicals**

**Length of Authorization: duration of need or lifetime.**

**NO PA REQUIRED**

CHLORPROMAZINE† (compare to Thorazine®)  
FLUPHENAZINE† (compare to Prolixin®, Prolixin®)  
HALOPERIDOL† (compare to Haldol®)  
LOXAPINE† (compare to Loxitane®)  
MOBAN® (molindone)  
PERPHENAZINE† (compare to Trilafon®)  
THIORIDAZINE† (compare to Mellaril®)  
THIOTHIXENE† (compare to Navane®)  
TRIFLUOPERAZINE† (compare to Stelazine®)

**PA REQUIRED**

Haldol®\*  
Loxitane®\*  
Mellaril®\*  
Navane®\*  
Prolixin®\*  
Thorazine®\*  
Trilafon®\*

### **PDL Key:**

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## BPH: Alpha Blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

DOXAZOSIN† (compare to Cardura®)  
FLOMAX® (tamsulosin)  
TERAZOSIN† (compare to Hytrin®)  
UROXATRAL® (alfuzosin)

### PA REQUIRED

Cardura®\*, Cardura XL®  
Hytrin®\*

## BPH: Androgen Hormone Inhibitors

*Length of Authorization: lifetime*

### NO PA REQUIRED

AVODART® (dutasteride)  
FINASTERIDE† (compare to Proscar®)  
PROSCAR® (finasteride)

### PA REQUIRED

Avodart® (dutasteride) females; males age < 45  
Finasteride† (compare to Proscar®) females; males age < 45  
Proscar® (finasteride) females; males age < 45

## Cardiac Glycosides:

*Length of Authorization: n/a*

### NO PA REQUIRED

DIGITEK® (digoxin)  
DIGOXIN†  
LANOXICAPS® (digoxin)  
LANOXIN® (digoxin)

### PA REQUIRED

## Chemical Dependency: Alcohol and Opiate Dependency

*Length of Authorization: 1 year*

*Special training and DEA number required for prescribers of Buprenorphine*

*Quantity limits apply*

*Vivitrol and Buprenorphine Therapy specific PA fax forms are available on OVHA website.*

### NO PA REQUIRED

**Alcohol Dependency**  
ANTABUSE® (disulfiram)  
CAMPRAL® (acamprosate)  
NALTREXONE oral † (compare to Revia®)

### PA REQUIRED

Revia®\* (naltrexone oral)  
Vivitrol® (naltrexone for extended-release injectable suspension) (*QL = 1 injection (380 mg) per 30 days*)  
  
Revia®\* (naltrexone oral)  
Suboxone® (buprenorphine with naloxone): 2 mg/0.5 mg and 8 mg/2 mg tablet  
Subutex® (buprenorphine): 2 mg and 8 mg tablets

### Opiate Dependency

NALTREXONE oral † (compare to Revia®)

Note: Methadone for opiate dependency can only be prescribed through a Methadone Maintenance Clinic

## Constipation: Chronic

*Length of Authorization: 3 months*

### NO PA REQUIRED

**Bulk-Producing Laxatives**  
PSYLLIUM†  
**Osmotic Laxatives**  
LACTULOSE†  
POLYETHYLENE GLYCOL 3350 (PEG)† (compare to Miralax®)

### PA REQUIRED

Amitiza® (lubiprostone)

## PDL Key:

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## Cough and Cold Preparations

*Length of Authorization: for date of service, no refills*

*Effective June 1, 2006*

### NO PA REQUIRED

All generics  
MUCINEX® (guaifenesin)

### PA REQUIRED

All brands

## Coronary Vasodilators/Antianginals: Oral

*Length of Authorization: 3 years*

*Quantity limits apply*

### NO PA REQUIRED

ISOSORBIDE DINITRATE† (compare to Isordil®)  
ISOSORBIDE MONONITRATE† (compare to Imdur®, Ismo®,  
Monoket®)  
NITROGLYCERIN  
NITROLINGUAL SPRAY  
NITROQUICK®  
NITROSTAT®  
NITRO-TIME®

### PA REQUIRED

BiDil®  
Dilatrate-SR®  
Imdur®\*  
Ismo®\*  
Isordil®\*  
Monoket®\*  
Ranexa® (ranolazine) (*QL = 4 tabs/day*)

## Coronary Vasodilators/Antianginals: Topical

*Length of Authorization: 3 years*

### NO PA REQUIRED

NITREK®  
NITRO PASTE†  
NITROGLYCERIN PATCHES† (compare to Minitran®, Nitro-Dur®)

### PA REQUIRED

Minitran®\*  
Nitro-Bid®\*  
Nitro-Dur®\*

## Gastrointestinals: H2-blockers

*Length of Authorization: 1 year*

### NO PA REQUIRED

CIMETIDINE† (compare to Tagamet®)  
FAMOTIDINE† (compare to Pepcid®)  
RANITIDINE† (compare to Zantac®) tablets  
ZANTAC® (ranitidine) SYRUP

### PA REQUIRED

Axid® §  
nizatadine †§  
Pepcid®\* §  
ranitidine† syrup  
Tagamet®\* §  
Zantac®/Zantac Effervescent® §

## Gastrointestinals: Proton Pump Inhibitors

*Length of Authorization: up to 1 year*

*Quantity limits apply*

♦ No PA required for patients <16 years; Quantity Limits still apply.

♣ No PA required for patients < 7 years; Quantity Limits still apply.

### NO PA REQUIRED FOR ONCE DAILY DOSES

PREVACID® (lansoprazole) capsules (*Quantity Limit=1 capsule/day*)  
PREVACID® (lansoprazole) packets (*Quantity Limit=1 packet/day*)  
PRILOSEC OTC® (omeprazole) *No Quantity Limit*  
PROTONIX® (pantoprazole) (*Quantity Limit=1 tablet/day*)

#### *H.Pylori eradication*

PREVPAC® (lansoprazole w/ H.pylori anti-bacterials) *No Quantity Limit*

### PA REQUIRED

Aciphex® (rabeprazole) § *Qty Limit=1 tablet/day*  
Nexium® (esomeprazole) capsules§ *Qty Limit=1 capsule/day*  
Nexium® (esomeprazole) powder for suspension § (*Qty limit=1 packet/day*)  
omeprazole generic♣ § *Qty Limit=1 capsule/day*  
Prevacid Solutabs®♣ *Qty Limit=1 tablet/day*  
Prilosec® (brand) § *Qty Limit=1 capsule/day*  
Zegerid®♣ (omeprazole powder for suspension) § *Qty Limit=1 powder packet/day*  
Zegerid® (omeprazole capsules) § *Qty Limit=1 capsule/day*

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## Glucocorticoids: Topical

*Length of Authorization: duration of prescription, up to 6 months.*

### NO PA REQUIRED

ALCLOMETASONE† (compare to Aclovate®)  
 DESONIDE† (compare to Tridesilon®)  
 FLUOCINOLONE 0.01%† (compare to Synalar®)  
 HYDROCORTISONE ACETATE† (all generics)

### PA REQUIRED

#### Low Potency

Aclovate®\*  
 Cortalid®\*  
 Desonate® gel (desonide)  
 Desowen®\*  
 Hytone®\*  
 Synalar®\* (all products)  
 Tridesilon®\*  
 All other brands

#### Medium Potency

BECLOMETHASONE DIPROPIONATE† (compare to Diprosone®, Maxivate®)  
 BETAMETHASONE VALERATE† (compare to Valisone®)  
 DESOXIMETASONE 0.05%† (compare to Topicort®)  
 FLUOCINOLONE 0.025%† (compare to Synalar®)  
 FLUTICASONE PROPRIONATE† (compare to Cutivate®)  
 HYDROCORTISONE BUTYRATE† (compare to Locoid®)  
 HYDROCORTISONE VALERATE† (compare to Westcort®)  
 MOMETASONE FUROATE† (compare to Elocon®)  
 TRIAMCINOLONE ACET.† (compare to Aristocort®)

Aristocort®\*  
 Cloderm® (clocortolone)  
 Cordran®\* (all products)  
 Cutivate®\*  
 Dermatop®  
 Diprosone®\*  
 Elocon®\* (all products)  
 Kenalog® (all products)  
 Locoid®  
 Luxiq Foam®  
 Synalar®\* (all products)  
 Topicort®\* (all products)  
 Westcort®\* (all products)  
 All other brands

#### High Potency

AMCINONIDE† (compare to Cyclocort®)  
 AUGM. BETHAMETH. CREAM† (compare to Diprolene®)  
 BETAMETHASONE DIPROP.† (compare to Diprosone®)  
 DESOXIMETASONE 0.25%† (compare to Topicort®)  
 DIFLORASONE DIAC.† (compare to Maxiflor®, Psorcon®)  
 FLUOCINOLONE 0.2%† (compare to Synalar®)  
 FLUOCINONIDE† (compare to Lidex®)

Cyclocort®\*  
 Diprolene®\* (all products)  
 Diprosone®\*  
 Halog®\* (all products)  
 Lidex®\* (all products)  
 Maxiflor®\*  
 Synalar®\* (all products)  
 Topicort®\* (all products)  
 All other brands

#### Very High Potency

AUGM. BETHAMETH. OINT.† (compare to Diprolene®)  
 CLOBETASOL PROPIONATE† (compare to Temovate®)  
 DIFLORASONE DIAC. EMOLL† (compare to Psorcon®)  
 HALOBETASOL PROPRIONATE† (compare to Ultravate®)

Cormax®  
 Diprolene®\* (all products)  
 Embeline E®\*  
 Olux®/Olux E®  
 Psorcon®\*  
 Temovate®\* (all products)  
 Ultravate®\* (all products)  
 All other brands

### PDL Key:

† Generic product

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## Growth Stimulating Agents

*Length of Authorization: up to 6 months; short bowel syndrome = 4 weeks.*

*Agents available after clinical criteria are met.*

*Therapy specific PA form is available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

NUTROPIN®  
NUTROPIN® AQ  
NUTROPIN® Depot  
TEV-TROPIN®  
  
INCRELEX® (mecasermin)

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Genotropin®  
Humatrop®  
Norditropin®  
Saizen®  
Serostim®  
Zorbtive® (with special criteria)

## Hepatitis C Agents

*Length of Authorization: 6 months*

*Therapy specific PA form is available on OVHA website.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

**RIBAVIRIN**  
RIBAVIRIN†

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

**RIBAVIRIN**  
Copegus®  
Ribasphere®  
Rebetol®  
**INTERFERON**  
Infergen® (interferon alfacon-1)  
Peg-Intron® (peg-interferon alpha-2b)  
**COMBINATION**  
Rebetron® (Rebetol/Intron-A)

## Hunter's Syndrome Injectables

*Length of Authorization: 1 year*

*Quantity limits apply*

### NO PA REQUIRED

### PA REQUIRED

Elaprase® (idursulfase) (*QL = calculated dose/week*)

## Immunomodulators: Topical

**\*\*Caution not approved for use in children under 2 years old\*\***

*Effective 11/1/06: PA required for Elidel / Protopic for children < 2 years. Quantity Limit = 30 gm / fill, 90 gm / 6 mos. Step Therapy required (previous trial of topical steroid for patients ≥ 2 yrs). Protopic ointment concentration limited to 0.03% for age < 16 years old.*

### NO PA REQUIRED

ELIDEL® (pimecrolimus) §  
PROTOPIC® (tacrolimus) §

### PA REQUIRED

Elidel® (age < 2 yrs)  
Protopic® (age < 2 yrs)

## Lipotropics: Bile Acid Sequestrants

*Length of Authorization: lifetime*

### NO PA REQUIRED

CHOLESTYRAMINE† powder (compare to Questran®)  
CHOLESTYRAMINE LIGHT† powder (compare to Questran Light®)  
PREVALITE† powder (cholestyramine light)

### PA REQUIRED

COLESTIPIOL† tablets, granules (compare to Colestid®)

Questran®\* powder (cholestyramine)  
Questran Light®\* powder (cholestyramine light)  
  
Colestid®\* tablets, granules (colestipol)  
Welchol® (colesevelam)

## PDL Key:

† Generic product

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## Lipotropics: Fibric Acid Derivatives

Length of Authorization: 1 year

### NO PA REQUIRED

- GEMFIBROZIL® † (compare to Lopid®)
- ♦TRICOR® (fenofibrate) §
- ♦TRIGLIDE® (fenofibrate) §

♦PA required if patient not on concurrent statin

### PA REQUIRED

- Antara® (fenofibrate micronized) §
- fenofibrate † §
- Lofibra® (fenofibrate micronized) §
- Lopid®\* (gemfibrozil) §

## Lipotropics: Niacin Derivatives

Length of Authorization: n/a

### NO PA REQUIRED

- NIACIN†
- NIASPAN® (niacin)

### PA REQUIRED

## Lipotropics: Statins

Length of Authorization: 1 year

### NO PA REQUIRED

- LESCOL® (fluvastatin)
- LESCOL® XL (fluvastatin XL)
- LOVASTATIN† (compare to Mevacor®)
- PRAVASTATIN† (compare to Pravachol®)

### PA REQUIRED

#### Low/Medium Potency Statins

- Altoprev® (lovastatin) §
- Mevacor®\* §
- Pravachol®\* (pravastatin) §

#### High Potency Statins

- CRESTOR® (rosuvastatin calcium)
- SIMVASTATIN†\*\*
- Lipitor® (atorvastatin) §
- Zocor®\* (simvastatin)

## Lipotropics: Miscellaneous/Combinations

Length of Authorization: 1 year

### NO PA REQUIRED

- ZETIA®\*\* (ezetimibe)
  - VYTORIN® (ezetimibe/simvastatin)
- \*\* If recipient is on Zetia® and simvastatin concurrently, change to Vytorin® is required.

### PA REQUIRED

#### Miscellaneous

- Omacor® (omega-3-acid ethyl esters)

#### Cholesterol Absorption Inhibitors/Combinations

- ADVICOR® (lovastatin/niacin)

#### Other Statin Combinations

- Caduet® (atorvastatin/amlodipine)

## Mood Stabilizers (see also Anticonvulsants)

Length of Authorization: duration of need or lifetime

### NO PA REQUIRED

- EQUETRO (carbamazepine)
- LITHIUM CARBONATE† (compare to Eskalith®)
- LITHIUM CARBONATE SR† (compare to Eskalith CR®, Lithobid®)
- LITHIUM CITRATE SYRUP†

### PA REQUIRED

- Eskalith CR®\* (lithium carbonate SR)
- Lithobid®\* (lithium carbonate SR)

## PDL Key:

† Generic product

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## Multiple Sclerosis: Injectables

Length of Authorization: 5 years

Quantity limits apply

### NO PA REQUIRED

BETASERON® (interferon B-1b)  
COPAXONE® (glatiramer acetate) (QL = 1 kit/30 days)  
REBIF® (interferon B-1a)

### PA REQUIRED

Avonex® (interferon B-1a)

## Nutritionals, enteral

Length of Authorization: 6 months

Therapy specific PA fax form available on OVHA website.

### NO PA REQUIRED

### PA REQUIRED

PA applies to oral (swallowed) liquid nutrition: Contact MedMetrics.  
For enteral nutrition requiring DME equipment and supplies call OVHA  
Clinical staff for authorization.

## Ophthalmics: Antihistamines

Length of Authorization: 1 year

### NO PA REQUIRED

ELESTAT® (epinastine)  
PATANOL® (olopatadine)

### PA REQUIRED

Emadine® (emedastine)  
ketotifen†  
Optivar® (azelastine)  
Zaditor® (ketotifen)

## Ophthalmics: Glaucoma Agents/Miotics

Length of Authorization: lifetime

### NO PA REQUIRED

#### ALPHA-2 ADRENERGIC

ALPHAGAN® P (brimonidine tartrate)  
BRIMONIDINE TARTARATE† (compare to Alphagan®)

### PA REQUIRED

Alphagan®  
Iopidine® (apraclonidine) - no PA required for pts <=10yrs

#### BETA BLOCKER

BETAXOLOL HCl† (compare to Betoptic®)  
BETOPTIC S® (betaxolol suspension)  
CARTEOLOL HCl† (compare to Ocupress®)  
LEVOBUNOLOL HCl† (compare to AKBeta®, Betagan®)  
METIPRANOLOL†(compare to Optipranolol®)  
TIMOLOL MALEATE† (compare to Istalol®, Timoptic®)

Betagan®\*  
Betimol®\*  
Istalol®\*  
Optipranolol®\*  
Timoptic®\*  
Timoptic XE®\*

#### PROSTAGLANDIN INHIBITORS

Note: Coverage of a 'preferred' PI agent is contingent upon a 1st-line trial of any other preferred beta-blocker, a-2 adrenergic or CAI agent. Coverage of a 'non-preferred' PI agent is contingent upon a similar first-line trial as well as a failed trial of both preferred PI products.

LUMIGAN® (bimatoprost) §  
TRAVATAN®/TRAVATAN Z® (travoprost) §

Xalatan® (latanoprost)

#### CARBONIC ANHYDRASE INHIBITOR

COSOPT® (dorzolamide w/timolol)  
TRUSOPT® (dorzolamide)

Azopt® (brinzolamide)

#### MISCELLANEOUS

DIPIVEFRIN HCl† (compare to AKPro®, Propine®)  
EPINEPHRINE† (compare to Epifrin®, Glaucon®\*)  
ISOPTO® CARBACHOL (carbachol)  
ISOPTO® CARPINE (pilocarpine)  
PILOCARPINE HCl† (compare to Pilocar®)  
PILOPINE® (pilocarpine)  
PHOSPHOLINE IODIDE® (echothiophate)

Carbastat®  
Miochol-E®  
Miostat®  
Pilocar®\*  
Propine®\*

#### **PDL Key:**

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## Ophthalmics: Mast Cell Stabilizers

*Length of Authorization: 6 months*

### NO PA REQUIRED

ALAMAST® (pemirolast potassium)  
CROMOLYN SODIUM† (compare to Crolom®, Opticrom®)

### PA REQUIRED

Alocril® (nedocromil sodium)  
Alomide® (iodoxamide)  
Crolom®\*

## Ophthalmics: Non-Steroidal Anti-inflammatory Drugs (NSAIDS)

*Length of Authorization: 1 year*

### NO PA REQUIRED

ACULAR® (ketorolac 0.5% ophthalmic sol.)  
ACULAR LS® (ketorolac 0.4% ophthalmic sol.)  
ACULAR® PF (ketorolac 0.5% ophthalmic sol.)  
FLURBIPROFEN 0.03% ophthalmic sol. †

### PA REQUIRED

Nevanac® ophthalmic susp. (nepafenac 0.1%)  
Xibrom® ophthalmic sol. (bromfenac 0.09%)  
Ocufen®\* ophthalmic sol. (flurbiprofen 0.03%)  
Voltaren® (diclofenac 0.1% ophthalmic sol.)

## Ophthalmics: Quinolone Anti-infectives

*Length of Authorization: for date of service, no refills*

### NO PA REQUIRED

CIPROFLOXACIN HCl† (compare to Ciloxan®)  
OFLOXACIN† (compare to Ocuflax®)

### PA REQUIRED

Ciloxan®\*  
Ocuflax®\*  
Quixin® (levofloxacin)  
Vigamox® (moxifloxacin)  
Zymar® (gatifloxacin)

## Ossification Enhancers

*Length of Authorization: lifetime*

**Quantity limits apply**

### NO PA REQUIRED

BONIVA® (ibandronate) 150 mg (*Quantity Limit = 1 tab/28 days*)  
BONIVA® (ibandronate) 2.5 mg *No quantity limits*  
FOSAMAX® (alendronate)  
FOSAMAX PLUS D® (alendronate/vitamin D)  
  
MIACALCIN® (calcitonin)

### PA REQUIRED

Actonel® (risedronate)  
Actonel® w/calcium (risedronate/calcium)  
Didronel® (etidronate)  
Skelid® (tiludronate)  
  
Fortical® (calcitonin)

## Otic: Anti-Infectives

*Length of Authorization: 1 year*

### NO PA REQUIRED

CIPRODEX® (ciprofloxacin 0.3%/dexamethasone 0.1%; otic susp.)  
  
FLOXIN® (ofloxacin 0.3%; otic soln.)  
  
NEOMYCIN/POLYMYXIN B SULFATE/HYDROCORTISONE †

### PA REQUIRED

Cipro-HC® (ciprofloxacin 0.2%/hydrocortisone 1%; otic susp.)  
  
Coly-Mycin S®/Cortisporin TC® (neomycin/colistin/thonzium/hydrocortisone)  
  
Cortisporin otic®/Pediotic®\* (neomycin/polymyxin B sulfate /hydrocortisone)  
otic solution/sus

## PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Parkinson's: Non-Ergot Dopamine Receptor Agonist

*Length of Authorization: 1 year*

**Quantity limits apply**

### NO PA REQUIRED

#### DOPAMINE PRECURSOR

CARBIDOPA/LEVODOPA† (compare to Sinemet®)  
PARCOPA® (carbidopa/levodopa ODT)

#### DOPAMINE AGONISTS

BROMOCRIPTINE† (compare to Parlodel®)  
MIRAPEX® (pramipexole)  
REQUIP® (ropinirole)

#### COMT INHIBITORS

TASMAR® (tolcapone)  
COMTAN® (entacapone)

#### MAO-B INHIBITORS

SELEGILINE† (compare to Eldepryl®)

#### OTHER

AMANTADINE† (compare to Symmetrel®)  
STALEVO® (carbidopa/levodopa/entacapone)

### PA REQUIRED

Sinemet® - all forms\* (brand)  
Sinemet CR®

Parlodel® (bromocriptine)

Eldepryl® (selegiline)  
Azilect® (rasagiline) (*QL = 1 mg/day*)  
Zelapar® (selegiline ODT) (*QL = 2.5 mg/day*)

Symmetrel® (amantadine)

## Phosphodiesterase-5 (PDE-5) Inhibitors

*Length of Authorization: 1 year*

**Quantity limits apply**

*Effective 7/1/06, phosphodiesterase-5 (PDE-5) inhibitors are no longer a covered benefit for all Vermont Pharmacy Programs for the treatment of erectile dysfunction. This change is resultant from changes set into effect January 1, 2006 and as detailed in Section 1903 (i)(21)(K) of the Social Security Act (the Act), precluding Medicaid Federal Funding for outpatient drugs used for the treatment of sexual or erectile dysfunction. Sildenafil will remain available for coverage via prior-authorization for the treatment of Pulmonary Arterial Hypertension.*

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Revatio® (sildenafil) (*Quantity Limit = 3 tabs/day*)  
Viagra® (sildenafil) (*Quantity Limit = 3 tabs/day*)

## Platelet Inhibitors

*Length of Authorization: 3 years*

### NO PA REQUIRED

ASPIRINT®  
CILOSTAZOL† (compare to Pletal®)  
CLOPIDOGREL† (compare to Plavix®)  
DIPYRIDAMOLE† (compare to Persantine®)  
PLAVIX® (clopidogrel bisulfate)  
TICLOPIDINE† (compare to Ticlid®)

### PA REQUIRED

Aggrenox® (dipyridamole/ASA)  
Persantine®\*  
Pletal®\*  
Ticlid®\*

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## **Psoriasis Injectables**

*Length of Authorization: initially for 3 months, and 6 months thereafter.*

**Quantity limits apply**

*Therapy-specific PA fax form available on OVHA website.*

### **PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

ENBREL® (etanercept) *QL = 50 mg x 8/month x 3 months, then 50 mg dose/week*  
RAPTIVA® (efalizumab) *(QL = 4 doses/month)*

### **NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET**

Amevive® *(QL = 4 doses/month)*  
Remicade® (infliximab)

## **Psoriasis: Non-Biologics**

*Length of Authorization: 1 year*

**Quantity limits apply**

### **NO PA REQUIRED**

CYCLOSPORINE † (all brand and generic)  
METHOTREXATE † (all brand and generic)  
OXSORALEN-ULTRA® (methoxsalen)  
SORIATANE® (acitretin)

### **PA REQUIRED**

#### Oral

DOVONEX® (calcipotriene cream/ointment)  
PSORIATEC®, DRITHO-SCALP® (anthralin cream)  
TAZORAC® (tazarotene cream)

#### Topical

Taclonex® (calcipotriene/betamethasone ointment)  
*(QL for initial fill = 60 grams)*

## **Pulmonary: Anticholinergics, Inhaled**

*Length of Authorization: n/a*

### **NO PA REQUIRED**

ATROVENT® (ipratropium)  
ATROVENT HFA® (ipratropium)  
COMBIVENT® (ipratropium/albuterol)  
DUONEB® (ipratropium/albuterol)  
SPIRIVA® (tiotropium)

### **PA REQUIRED**

## **Pulmonary: Antihistamines-2<sup>nd</sup> Gen.**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

FEXOFENADINE § (after 15-day loratadine trial and failure w/in last 30 days)  
LORATADINE (OTC) † all forms  
LORATADINE/D (OTC) †  
ZYRTEC® (cetirizine) SYRUP (age <12 yrs)  
\* other OTC products are not covered.

### **PA REQUIRED**

Allegra® (fexofenadine) §  
Allegra® suspension §  
Allegra-D® § (12 HR & 24 HR)  
Clarinet® (desloratadine) §  
Clarinet-D® § (12 HR & 24 HR)  
Claritin® Syrup §  
Claritin RediTabs® §  
Zyrtec® (cetirizine) §  
Zyrtec-D® §  
Zyrtec® Chewable Tablets §  
Zyrtec® Syrup § (age ≥ 12 years)  
All other branded  
Antihistamine/decongestant combinations

## **Pulmonary: Persistent Asthma**

*Length of Authorization: 3 months after clinical criteria are met.*

*Therapy specific clinical criteria are available on the OVHA website.*

### **NO PA REQUIRED**

### **PA REQUIRED**

Xolair® (omalizumab)

## **PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

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## Pulmonary: Beta-adrenergic Agents

*Length of Authorization: 5 years*

*Effective 11/1/06: Albuterol Sulfate MDI moves to "PA REQUIRED" (existing users of this product will maintain coverage without prior authorization indefinitely via grandfathering provisions)*

### NO PA REQUIRED

#### METERED-DOSE INHALERS (SHORT-ACTING)

XOPENEX® HFA (levalbuterol)

### PA REQUIRED

- albuterol MDI†  
Alupent® (metaproterenol)  
Maxair® Autohaler (pirbuterol)  
• Proair® (albuterol)  
• Proventil® HFA (albuterol)  
• Ventolin® HFA (albuterol)

*• coverage grandfathered for current users*

#### METERED-DOSE INHALERS (LONG-ACTING)

SEREVENT® DISKUS (salmeterol xinafoate) (*after criteria for LABA are met*)

Foradil® (formoterol)

### NEBULIZER SOLUTIONS

ACCUNEB®

ALBUTEROL NEBS†

METAPROTERENOL† (compare to Alupent®)

XOPENEX® neb solution (levalbuterol HCL) (age ≤ 12 yrs)

Xopenex® neb solution (age > 12 yrs)

Airet®\* (albuterol)

### TABLETS/SYRUP (SHORT-ACTING)

TERBUTALINE† tablets (compare to Brethine®)

Brethine®\* (terbutaline)

ALBUTEROL † tablets/syrup

METAPROTERENOL †tablets/syrup

### TABLETS (LONG-ACTING)

ALBUTEROL ER † tablets

Vospire ER®\* (albuterol)

## Pulmonary: Inhaled Glucocorticoids/Glucocorticoid Combinations

*Length of Authorization: 5 years*

### NO PA REQUIRED

ADVAIR® (fluticasone/salmeterol)

ADVAIR® HFA (fluticasone/salmeterol)

ASMANEX® (mometasone furoate)

AZMACORT® (triamcinolone acetonide)

FLOVENT® HFA (fluticasone propionate) (*QL = 36 gm(3 inhalers)/90 days*)

PULMICORT RESPULES® (budesonide) (age ≤ 12 yrs)

QVAR® (beclomethasone)

### PA REQUIRED

AeroBid® (flunisolide) §

AeroBid-M® §

Pulmicort (budesonide) Respules® (age > 12 yrs)

Pulmicort Turbuhaler® §

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Pulmonary: Nasal Glucocorticoids

Length of Authorization: 5 years

### NO PA REQUIRED

FLONASE® (fluticasone propionate)  
FLUNISOLIDE† (compare to Nasalide®)  
NASACORT AQ® (triamcinolone AQ)  
NASONEX® (mometasone)

### PA REQUIRED

Beconase AQ® (beclomethasone AQ)  
Fluticasone† (compare to Flonase®)  
Nasacort® HFA (triamcinolone HFA)  
Nasarel® (flunisolide)  
Rhinocort AQ® (budesonide AQ)

## Pulmonary: Systemic Glucocorticoids

Length of Authorization: 1 year

### NO PA REQUIRED

CORTISONE ACETATE†  
DEXAMETHASONE† (compare to Decadron®)  
HYDROCORTISONE†  
METHYLPREDNISOLONE† (compare to Medrol®)  
ORAPRED® (prednisolone sod phosphate) (age < 12 yrs)  
PREDNISOLONE† tabs / liquid (compare to Prelone®)  
PREDNISONE† (compare to Deltasone)

### PA REQUIRED

Aristocort®\*  
Celestone®\*  
Cortef®  
Decadron®\*  
Deltasone®\*  
Kenalog®\*  
Medrol®\*

Orapred® (age ≥ 12 yrs)  
Pediapred®\*  
Prelone®\*  
Any dose packaging (i.e.: Dosepak)

## Pulmonary: Leukotriene Modifiers

Length of Authorization: 1 year

### NO PA REQUIRED

ACCOLATE® (zaflurkast)  
SINGULAIR® (montelukast sodium)

### PA REQUIRED

ZyFlo® (zileuton) §

## Pulmonary: RSV Prevention

Length of Authorization: 1 season, 6 doses (October 1-April 15)

Quantity limits apply

### NO PA REQUIRED

PA REQUIRED: Therapy specific PA fax form is available on the OVHA website

SYNAGIS® (palivizumab)

## Renal Disease: Phosphate Binders

Length of Authorization: n/a

### NO PA REQUIRED

FOSRENOL® (lanthanum carbonate)  
PHOS LO® (calcium acetate)  
RENAGEL® (sevelamer)

### PA REQUIRED

## Rheumatoid Arthritis: Immunomodulators

Length of Authorization: initial 3 months, re-evaluate every 12 months

Quantity limits apply

Therapy specific PA fax form is available on the OVHA website.

### PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

HUMIRA® (adalimumab) QL = 2 syringes/month  
ENBREL® (etanercept) QL = 8 doses/month

### NON-PREFERRED AGENTS AFTER CLINICAL CRITERIA ARE MET

Kineret® QL = 28 syringes/month

### PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## Sedative/Hypnotics

*Length of Authorization: 1 year*

**Quantity limits apply**

**NO PA REQUIRED**

CHLORAL HYDRATE† syrup, suppository  
ESTAZOLAM† (compare to Prosom®)  
FLURAZEPAM† (compare to Dalmane®)  
TEMAZEPAM† (compare to Restoril®)

**PA REQUIRED**

### Benzodiazepine

Dalmane®\*  
Doral® (quazepam)  
Prosom®\*  
Restoril®\*  
Somnot®  
Triazolam and Halcion®

### Non-benzodiazepine

LUNESTA® (eszopiclone) (*Quantity Limit = 1 tab/day*)  
ZOLPIDEM † (compare to Ambien®) (*Quantity Limit = 1 tab/day*)

Ambien®\* (zolpidem) (*Quantity Limit = 1 tab/day*)  
Ambien CR® (zolpidem) (*Quantity Limit = 1 tab/day*)  
Rozerem® (ramelteon) (*Quantity Limit = 1 tab/day*)  
Sonata® (zaleplon)

## Skeletal Muscle Relaxants

*Length of Authorization: 1 year*

*Effective 11/1/06: All carisoprodol products (brand and generics) move to "PA REQUIRED"*

**NO PA REQUIRED**

CHLORZOXAZONE† (compare to Parafon Forte DSC®)  
CYCLOBENZAPRINE† (compare to Flexeril®)  
METHOCARBAMOL† (compare to Robaxin®)  
METHOCARBAMOL, ASA† (compare to Robaxisal®)  
ORPHENADRINE CITRATE† (compare to Norflex®)  
ORPHENADRINE, ASA, CAFFEINE† (compare to Norgesic®, Norgesic Forte®)

**PA REQUIRED**

### Musculoskeletal Agents

carisoprodol †  
carisoprodol, ASA†  
carisoprodol, ASA, codeine †  
Flexeril®\*  
Norflex®\*  
Norgesic®\*  
Norgesic Forte®\*  
Parafon Forte DSC®\*  
Robaxin®\*  
Robaxisal®\*  
Skelaxin®  
Soma®  
Soma Compound®  
Soma Compound with Codeine®

*ASA = aspirin*

### Antispasticity Agents

BACLOFEN† (compare to Lioresal®)  
DANTROLENE† (compare to Dantrium®)  
TIZANIDINE† (compare to Zanaflex®)

Dantrium®\*  
Lioresal®\*  
Zanaflex®\*

## PDL Key:

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)

## **Smoking Cessation Therapies**

*Length of Authorization: see table*

**Quantity limits apply**

### **NO PA REQUIRED**

#### **NICOTINE REPLACEMENT (maximum duration is 16 weeks (2 x 8 weeks)/365 days)▲**

NICODERM CQ PATCH®  
 NICORETTE GUM®  
 COMMIT LOZENGE®  
 NICOTINE LOZENGE†  
 NICOTROL INHALER®

### **ORAL THERAPY**

BUPROPION SR†  
 CHANTIX® (varenicline) (Limited to 18 years and older, Quantity Limit = 2 tabs/day, maximum duration 24 weeks (2 x 12 weeks)/365 days)▲

### **PA REQUIRED**

nicotine patch OTC†  
 nicotine patch RX† (compare to Habitrol®)  
 Nicotine System Kit®  
 nicotine gum†  
 Nicotrol Nasal Spray®

Zyban®\* (bupropion SR)  
 (maximum duration 24 weeks (2 x 12 weeks)/365 days)

▲ For approval of therapy beyond the established maximum duration, the prescriber must provide evidence that the patient is engaged in a smoking cessation counseling program.

## **Urinary Antispasmodics**

*Length of Authorization: 1 year*

### **NO PA REQUIRED\***

#### **SHORT-ACTING AGENTS**

OXYBUTYNIN† (compare to Ditropan®)

#### **LONG-ACTING AGENTS**

DITROPAN XL® (oxybutynin XL)  
 ENABLEX® (darifenacin)  
 VESICARE® (solifenacain)

### **PA REQUIRED**

Ditropan®\*

Detrol® (tolterodine)  
 Detrol LA® (tolterodine LA)  
 Oxybutynin XL†  
 Oxytrol® (oxybutynin transdermal)  
 Sanctura® (trospium)  
 Urispas® (flavoxate)

#### **>NOTE:**

- Patients under the age of 65 must fail an adequate trial of generic oxybutynin before approval will be granted for either Ditropan XL®, Vesicare® or Enablex®.
- A therapeutic failure on at least two preferred products is required before a PA will be approved on any non-preferred medication, regardless of patient age.

Recipients < 21 years of age are exempt from all PA Requirements.  
 (Exception: An adequate trial of Ditropan XL will be required before approval of oxybutynin XL will be granted)

## **Vaginal Anti-Infectives**

*Length of Authorization: 1 year*

### **NO PA REQUIRED**

#### **CLINDAMYCIN**

CLINDAMYCIN VAGINAL† (clindamycin vaginal cream 2%)  
 CLINDAMAX† (clindamycin vaginal cream 2%)

### **PA REQUIRED**

Cleocin®\* (clindamycin vaginal cream 2%)  
 Clindesse® (clindamycin vaginal cream 2%)  
 Cleocin® Vaginal Ovules (clindamycin vaginal suppositories)

#### **METRONIDAZOLE**

METROGEL VAGINAL® (metronidazole vaginal gel 0.75%)

metronidazole vaginal gel 0.75%†  
 Vandazole† (metronidazole vaginal 0.75%)

### **PDL Key:**

† Generic product

\* Indicates a generic equivalent is available without PA

§ Indicates drug is managed via automated Step Therapy (prerequisite drug therapy automatically screened for upon claims processing)